THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

CHAPTER 34
DISABILITY INSURANCE POLICIES

500.3400 Policy of disability insurance; scope of chapter, exemptions, exceptions.

Sec. 3400. (1) The term "policy of disability insurance" as used in this chapter includes any policy or contract of insurance against loss resulting from sickness or from bodily injury or death by accident, or both, including also the granting of specific hospital benefits and medical, surgical and sick-care benefits to any person, family or group, subject to the exclusions set forth or referred to in this section.

(2) Nothing in this chapter shall apply to or affect:

(a) Any policy of liability or workmen's compensation insurance, with or without supplementary expense coverage therein;

(b) Any policy or contract of reinsurance; or

(c) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to disability insurance as (i) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (ii) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract; all of which supplemental contracts shall be issuable under authority of section 602.

(3) The provisions of this chapter contained in sections 3407 (entire contract; changes), 3411 (reinstatement), and 3420 (physical examinations and autopsy), may be omitted from ticket policies sold only to passengers by common carriers.

(4) Section 3475 of this chapter shall apply to group, blanket or family expense disability insurance contracts and the remaining provisions of this chapter shall apply to such contracts only as provided in chapter 36.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1963, Act 56, Eff. Sept. 6, 1963.

Popular name: Act 218

500.3401 Purpose of chapter; short title, uniform disability insurance policy provisions law.

Sec. 3401. (1) The purpose of this chapter is to provide for a new set of standard provisions applicable to disability insurance policies, which it is proposed shall become substantially uniform throughout the various states; to provide that adoption of their use by insurers shall be optional before January 1, 1956; and upon that date shall be mandatory; which date of adoption in either instance is referred to herein as the operative date of this chapter.

(2) This chapter shall be known and may be cited as the uniform disability insurance policy provisions law.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3402 Disability insurance policy; provisions required.

Sec. 3402. No policy of disability insurance, as defined in section 3400 (1), shall be delivered or issued for delivery to any person in this state unless:

(1) The entire money and other considerations therefor are expressed therein; and

(2) The time at which the insurance takes effect and terminates is expressed therein; and

(3) It purports to insure only 1 person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any 2 or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder; and

(4) The style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point with a lower-case unspaced alphabet length, not less than 120-point in length of line (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions); and

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in sections 3406 through 3454, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as **"EXCEPTIONS"**, or

"EXCEPTIONS AND REDUCTIONS": Provided, That if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(7) It contains no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3403 Individual disability insurance policy; coverage for newly born children; notice of birth; payment of premium.

Sec. 3403. (1) Individual disability insurance policies providing coverage on an expense incurred basis which provide coverage for a family member of the insured shall, as to that family member's coverage, also provide that the disability insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth.

(2) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child and payment of the required premium shall be furnished to the insurer within 31 days after the date of birth in order to have the coverage continue beyond the 31-day period.

History: Add. 1975, Act 20, Imd. Eff. Apr. 3, 1975.

Compiler's note: Section 2 of Act 20 of 1975 provides: "The requirements of this act shall apply to all insurance policies delivered or issued for delivery in this state more than 120 days after the effective date of the act."

Popular name: Act 218

500.3404 Disability insurance policies issued for delivery to nonresident.

Sec. 3404. If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in section 3402 and in sections 3406 through 3466.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3405 Prudent purchaser agreements with providers of hospital, nursing, medical, surgical, or sick-care services; disability insurance policies; rates; discrimination prohibited; prior contracts and renewal; optometric and chiropractic service; conditional effective date of subsection (8).

Sec. 3405. (1) For the purpose of doing business as an organization under the prudent purchaser act, Act No. 233 of the Public Acts of 1984, being sections 550.51 to 550.63 of the Michigan Compiled Laws, an insurer authorized in this state to write disability insurance that provides coverage for hospital, nursing, medical, surgical, or sick-care benefits may enter into prudent purchaser agreements with providers of hospital, nursing, medical, surgical, or sick-care services pursuant to this section and Act No. 233 of the Public Acts of 1984.

(2) An insurer may offer disability insurance policies under which the insured persons shall be required, as a condition of coverage, to obtain hospital, nursing, medical, surgical, or sick-care services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom such a policy is offered shall also be offered a policy that:

(a) Does not, as a condition of coverage, require insured persons to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to an insured person who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(3) An insurer may offer disability insurance policies under which insured persons who elect to obtain hospital, nursing, medical, surgical, or sick-care services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such

providers. Policies offered pursuant to this subsection shall not, as a condition of coverage, require insured persons to obtain such services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom such a policy is offered shall also be offered a policy that:

(a) Does not, as a condition of coverage, require insured persons to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to an insured person who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(4) The rates charged by an insurer for coverage under policies issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the insurer for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(5) An insurer shall not discriminate against a class of health care providers when entering into prudent purchaser agreements with health care providers for its provider panel. This subsection does not:

(a) Prohibit the formation of a provider panel consisting of a single class of providers when a service provided for in the specifications of a purchaser may legally be provided only by a single class of providers.

(b) Prohibit the formation of a provider panel that conforms to the specifications of a purchaser of the coverage authorized by this section so long as the specifications do not exclude any class of health care providers who may legally perform the services included in the coverage.

(c) Require an organization that has uniformly applied the standards filed pursuant to section 3(3) of Act No. 233 of the Public Acts of 1984, being section 550.53 of the Michigan Compiled Laws, to contract with any individual provider.

(6) Nothing in this 1984 amendatory act applies to any contract that is in existence before December 20, 1984, or the renewal of such contract.

(7) Notwithstanding any other provision of this act, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, an insurer is not required to provide coverage or reimburse for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, Act No. 368 of the Public Acts of 1978 , being section 333.17401 of the Michigan Compiled Laws, as of May 20, 1992.

(8) Notwithstanding any other provision of this act, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of chiropractic, an insurer is not required to provide coverage or reimburse for the use of therapeutic sound or electricity, or both, for the reduction or correction of spinal subluxations in a chiropractic service. This subsection shall not take effect unless Senate Bill No. 493 of the 87th Legislature is enacted into law.

History: Add. 1984, Act 280, Imd. Eff. Dec. 20, 1984;—Am. 1989, Act 137, Eff. Jan. 3, 1990;—Am. 1994, Act 438, Eff. Mar. 30, 1995.

Compiler's note: Senate Bill No. 493 was not enacted into law by the 87th Legislature.

Popular name: Act 218

500.3406 Disability insurance policy; provisions required, captions, omissions, substitutions.

Sec. 3406. (1) Except as provided in subsection (2) of this section, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in sections 3407 through 3424 in the words in which the same appear in such sections: Provided, however, That the insurer may, at its option, substitute for 1 or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in the pertinent section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(2) If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3406a Hospital, medical, or surgical expense incurred policy; mastectomy benefit coverage required.

Sec. 3406a. A hospital, medical or surgical expense incurred policy shall offer benefits for prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy. This coverage shall provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage intended by this section.

History: Add. 1982, Act 527, Eff. Mar. 30, 1983.

Popular name: Act 218

500.3406b Coverage for mental health services by mental health care provider.

Sec. 3406b. A policy or certificate which provides coverage for mental health services shall provide coverage for mental health services provided to an individual by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if the provider of the mental health services is designated by an order of a court; provided that the mental health provider meets the standards set by the insurer for all other providers of the type.

History: Add. 1984, Act 280, Imd. Eff. Dec. 20, 1984.

Popular name: Act 218

500.3406c Hospice care; definition; description of coverage.

Sec. 3406c. (1) An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy that provides coverage for inpatient hospital care shall offer to include coverage for hospice care. As used in this section, "hospice" means hospice as defined in section 20106 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.20106 of the Michigan Compiled Laws.

(2) If hospice care coverage is provided, a description of the hospice coverage shall be included in communications sent to the insured.

History: Add. 1984, Act 368, Eff. Jan. 1, 1986;—Am. 1994, Act 233, Imd. Eff. June. 30, 1994.

Popular name: Act 218

500.3406d Coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services; coverage for breast cancer screening mammography; definitions; effective date of section.

Sec. 3406d. (1) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, an insurer which delivers, issues for delivery, or renews in this state a hospital, medical, or surgical expense incurred policy shall offer or include coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

(2) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, an insurer which delivers, issues for delivery, or renews in this state a hospital, medical, or surgical expense incurred policy shall offer or include the following coverage for breast cancer screening mammography:

(a) If performed on a woman 35 years of age or older and under 40 years of age, coverage for 1 screening mammography examination during that 5-year period.

(b) If performed on a woman 40 years of age or older, coverage for 1 screening mammography examination every calendar year.

(3) As used in this section:

(a) "Breast cancer diagnostic services" means a procedure intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammography, surgical breast biopsy, and pathologic examination and interpretation.

(b) "Breast cancer rehabilitative services" means a procedure intended to improve the result of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to reconstructive plastic surgery, physical therapy, and psychological and social support services.

(c) "Breast cancer screening mammography" means a standard 2-view per breast, low-dose radiographic examination of the breasts, using equipment designed and dedicated specifically for mammography, in order to detect unsuspected breast cancer.

(d) "Breast cancer outpatient treatment services" means a procedure intended to treat cancer of the human

breast, delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

(4) This section shall take effect November 1, 1989.

History: Add. 1989, Act 59, Eff. Nov. 1, 1989.

Popular name: Act 218

500.3406e Coverage for drug used in antineoplastic therapy and cost of its administration; conditions.

Sec. 3406e. An insurer which delivers, issues for delivery, or renews in this state a hospital, medical, or surgical expense incurred policy shall provide coverage in each policy for a drug used in antineoplastic therapy and the reasonable cost of its administration. Coverage shall be provided for any federal food and drug administration approved drug regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the federal food and drug administration if all of the following conditions are met:

(a) The drug is ordered by a physician for the treatment of a specific type of neoplasm.

(b) The drug is approved by the federal food and drug administration for use in antineoplastic therapy.

(c) The drug is used as part of an antineoplastic drug regimen.

(d) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.

(e) The physician has obtained informed consent from the patient for the treatment regimen which includes federal food and drug administration approved drugs for off-label indications.

History: Add. 1989, Act 59, Imd. Eff. June 16, 1989.

Popular name: Act 218

500.3406f Excluded or limited coverage; "group" defined; applicability of section; crediting prior continuous health care coverage; examination by commissioner and director; report.

Sec. 3406f. (1) An insurer may exclude or limit coverage for a condition as follows:

(a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under subdivision (b) or (c), only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

(b) For an individual covered under a group policy or certificate covering 2 to 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

(c) For an individual covered under a group policy or certificate covering more than 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the policy or certificate.

(2) As used in this section, "group" means a group health plan as defined in section 2791(a)(1) and (2) of part C of title XXVII of the public health service act, chapter 373, 110 Stat. 1972, 42 U.S.C. 300gg-91, and includes government plans that are not federal government plans.

(3) This section applies only to an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate. This section does not apply to any policy or certificate that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, or 1-time limited duration policy or certificate of no longer than 6 months.

(4) The commissioner and the director of community health shall examine the issue of crediting prior continuous health care coverage to reduce the period of time imposed by preexisting condition limitations or exclusions under subsection (1)(a), (b), and (c) and shall report to the governor and the senate and the house of representatives standing committees on insurance and health policy issues by May 15, 1997. The report shall include the commissioner's and director's findings and shall propose alternative mechanisms or a combination of mechanisms to credit prior continuous health care coverage towards the period of time imposed by a preexisting condition limitation or exclusion. The report shall address at a minimum all of the following:

(a) Cost of crediting prior continuous health care coverages.

(b) Period of lapse or break in coverage, if any, permitted in a prior health care coverage.

(c) Types and scope of prior health care coverages that are permitted to be credited.

(d) Any exceptions or exclusions to crediting prior health care coverage.

(e) Uniform method of certifying periods of prior creditable coverage.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997.

Popular name: Act 218

500.3406g Policy or certificate offering dependent coverage to child; denial of enrollment on certain grounds prohibited.

Sec. 3406g. An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate that offers dependent coverage shall not deny enrollment to an insured's child on any of the following grounds:

(a) The child was born out of wedlock.

(b) The child is not claimed as a dependent on the insured's federal income tax return.

(c) The child does not reside with the insured or in the insurer's service area.

History: Add. 1995, Act 237, Eff. Mar. 28, 1996.

Popular name: Act 218

500.3406h Eligibility of parent for dependent coverage; health coverage of child through noncustodial parent; duties of insurer; court or administrative order and notice required.

Sec. 3406h. (1) If a parent is eligible for dependent coverage through an insurer, the insurer shall:

(a) Permit the parent to enroll, under the dependent coverage, a child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under dependent coverage upon application by the friend of the court or by the child's other parent through the friend of the court.

(c) Not eliminate the child's coverage unless premiums have not been paid as required by the policy or certificate or the insurer is provided with satisfactory written evidence of either of the following:

(*i*) The court or administrative order is no longer in effect.

(*ii*) The child is or will be enrolled in comparable health coverage through another insurer, health care corporation, health maintenance organization, or self-funded health coverage plan that will take effect not later than the effective date of the cancellation of the existing coverage.

(2) If a child has health coverage through an insurer of a noncustodial parent, that insurer shall do all of the following:

(a) Provide the custodial parent with information necessary for the child to obtain benefits through that coverage.

(b) Permit the custodial parent or, with the custodial parent's approval, the provider to submit a claim for covered services without the noncustodial parent's approval.

(c) Make payment on claims submitted under subdivision (b) directly to the custodial parent or medical provider.

(3) This section applies only if a parent is required by a court or administrative order to provide health coverage for a child and the insurer is notified of that court or administrative order.

History: Add. 1995, Act 237, Eff. Mar. 28, 1996.

Popular name: Act 218

500.3406i Individual eligible under title XIX of social security act; assignment of rights of insured to department of social services.

Sec. 3406i. (1) An insurer shall not consider whether an individual is eligible for or has available medical assistance under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396v, in this or another state when considering eligibility for coverage or making payments under its plan for eligible insureds.

(2) If an insurer has a legal liability to make payments, and payment for covered expenses for medical goods or services furnished to an individual has been made under the medical assistance program established under section 105 of the social welfare act, Act No. 280 of the Public Acts of 1939, being section 400.105 of the Michigan Compiled Laws, the department of social services has the rights of the individual to payment by the insurer to the extent payment was made by the department of social services's medical assistance program for those medical goods or services.

(3) If the department of social services has been assigned the rights of an insured who is eligible for medical assistance under section 105 of Act No. 280 of the Public Acts of 1939 and is covered by an insurer,

the insurer shall not impose requirements on the department of social services that are different from requirements that apply to an agent or assignee of any other covered insured.

History: Add. 1995, Act 237, Eff. Mar. 28, 1996.

Popular name: Act 218

500.3406j Insured or applicant for expense-incurred hospital, medical, or surgical policy or certificate as victim of domestic abuse; refusal to provide coverage prohibited; exception; liability; applicability to policies or certificates on or after June 1, 1998; "domestic violence" defined.

Sec. 3406j. (1) An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate shall not rate, cancel coverage on, refuse to provide coverage for, or refuse to issue or renew a policy or certificate solely because an insured or applicant for insurance is or has been a victim of domestic violence.

(2) This section does not prohibit an insurer from inquiring about, underwriting, or charging a different premium on the basis of the individual's physical or mental condition, regardless of the cause of the condition.

(3) An insurer shall not be held civilly liable for any cause of action that may result from compliance with this section.

(4) This section applies to policies and certificates issued or renewed on or after June 1, 1998.

(5) As used in this section, "domestic violence" means inflicting bodily injury, causing serious emotional injury or psychological trauma, or placing in fear of imminent physical harm by threat or force a person who is a spouse or former spouse of, has or has had a dating relationship with, resides or has resided with, or has a child in common with the person committing the violence.

History: Add. 1998, Act 136, Imd. Eff. June 24, 1998.

Popular name: Act 218

500.3406k Emergency health services; medical services coverage; "stabilization" defined.

Sec. 3406k. (1) An expense-incurred hospital, medical, or surgical policy or certificate delivered, issued for delivery, or renewed in this state that provides coverage for emergency health services and a health maintenance organization contract shall provide coverage for medically necessary services provided to an insured for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An insurer shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. An insurer shall not deny payment for emergency health services up to the point of stabilization provided to an insured under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization was not given by the insurer before emergency health services were provided.

(2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

History: Add. 1998, Act 125, Imd. Eff. June 10, 1998;—Am. 2004, Act 7, Imd. Eff. Feb. 20, 2004.

Popular name: Act 218

500.3406*l* Medical transportation services; reimbursement.

Sec. 3406*l*. (1) Except as otherwise provided in subsections (2) and (3), an expense-incurred hospital, medical, or surgical policy or certificate that provides benefits for emergency services shall provide for direct reimbursement to any provider of covered medical transportation services or shall provide that payment be made jointly to the insured and the provider, if that provider has not received payment for those services from any other source.

(2) Subsection (1) does not apply to a transaction between an insurer and a medical transportation service provider if the parties have entered into a contract providing for direct payment.

(3) An insurer for a policy or certificate issued under section 3405 or 3631 does not have to provide for direct reimbursement to any nonaffiliated or nonparticipating provider for medical transportation services that were not emergency health services as defined in section 3406k.

(4) Subsection (1) applies to an expense-incurred hospital, medical, or surgical policy or certificate that provides benefits for emergency health services if the policy or certificate is delivered, issued for delivery, or renewed in this state on or after September 1, 2004.

(5) This section does not apply to a health maintenance organization contract.

History: Add. 2004, Act 171, Imd. Eff. June 24, 2004.

Popular name: Act 218

500.3406m Access by insured to obstetrician-gynecologist.

Sec. 3406m. (1) An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate that requires an insured to designate a participating primary care provider and provides for annual well-woman examinations and routine obstetrical and gynecologic services shall permit a female insured to access an obstetrician-gynecologist for annual well-woman examinations and routine obstetrical and gynecologic services.

(2) An insurer shall not require prior authorization or referral for access under subsection (1) to an obstetrician-gynecologist who is participating with the insurer. An insurer may require prior authorization or referral for access to a nonparticipating obstetrician-gynecologist.

(3) A description of the coverage provided by this section shall be included by the insurer in a communication sent to the insured or group purchaser of coverage.

History: Add. 1998, Act 402, Eff. Mar. 23, 1999.

Popular name: Act 218

500.3406n Access to pediatric services.

Sec. 3406n. (1) An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate that requires an insured to designate a participating primary care provider and provides for dependent care coverage shall permit a dependent minor insured to select and access a pediatrician for general pediatric care services.

(2) An insurer shall not require prior authorization or referral for access under subsection (1) to a pediatrician who participates with the insurer. An insurer may require prior authorization or referral for access to a nonparticipating pediatrician.

History: Add. 1999, Act 179, Imd. Eff. Nov. 16, 1999.

Popular name: Act 218

500.3406o Insurer providing prescription drug coverage; formulary restrictions.

Sec. 3406o. An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate that provides coverage for prescription drugs and limits those benefits to drugs included in a formulary shall do all of the following:

(a) Provide for participation of participating physicians, dentists, and pharmacists in the development of the formulary.

(b) Disclose to health care providers and upon request to insureds the nature of the formulary restrictions.

(c) Provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative. This subdivision does not prevent an insurer from establishing prior authorization requirements or another process for consideration of coverage or higher cost-sharing for nonformulary alternatives. Notice as to whether or not an exception under this subdivision has been granted shall be given by the insurer within 24 hours after receiving all information necessary to determine whether the exception should be granted.

History: Add. 1999, Act 177, Imd. Eff. Nov. 16, 1999.

Popular name: Act 218

500.3406p Establishment of program to prevent onset of clinical diabetes required; report; coverages; "diabetes" defined.

Sec. 3406p. (1) An insurer providing an expense-incurred hospital, medical, or surgical policy or certificate delivered or issued for delivery in this state and a health maintenance organization shall establish and provide to insureds, enrollees, and participating providers a program to prevent the onset of clinical diabetes. This program for participating providers shall emphasize best practice guidelines to prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment.

(2) An insurer and a health maintenance organization providing a program pursuant to subsection (1) shall regularly measure the effectiveness of the program by regularly surveying individuals covered by the policy, certificate, or contract. Not later than 2 years after the effective date of the amendatory act that added this section, each insurer and health maintenance organization providing a program pursuant to subsection (1) shall prepare a report containing the results of the survey and shall provide a copy of the report to the department of community health.

(3) An expense-incurred hospital, medical, or surgical policy or certificate delivered or issued for delivery in this state and a health maintenance organization contract shall include coverage for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary and prescribed by an allopathic or osteopathic physician:

(a) Blood glucose monitors and blood glucose monitors for the legally blind.

(b) Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.

(c) Syringes.

(d) Insulin pumps and medical supplies required for the use of an insulin pump.

(e) Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition.

(4) An expense-incurred hospital, medical, or surgical policy or certificate delivered or issued for delivery in this state and a health maintenance organization contract that provides outpatient pharmaceutical coverage directly or by rider shall include the following coverage for the treatment of diabetes, if determined to be medically necessary:

(a) Insulin, if prescribed by an allopathic or osteopathic physician.

(b) Nonexperimental medication for controlling blood sugar, if prescribed by an allopathic or osteopathic physician.

(c) Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes, if prescribed by an allopathic, osteopathic, or podiatric physician.

(5) Coverage under subsection (3) for diabetes self-management training is subject to all of the following:

(a) Is limited to completion of a certified diabetes education program upon occurrence of either of the following:

(*i*) If considered medically necessary upon the diagnosis of diabetes by an allopathic or osteopathic physician who is managing the patient's diabetic condition and if the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.

(*ii*) If an allopathic or osteopathic physician diagnoses a significant change with long-term implications in the patient's symptoms or conditions that necessitates changes in a patient's self-management or a significant change in medical protocol or treatment modalities.

(b) Shall be provided by a diabetes outpatient training program certified to receive medicaid or medicare reimbursement or certified by the department of community health. Training provided under this subdivision shall be conducted in group settings whenever practicable.

(6) Coverage under this section is not subject to dollar limits, deductibles, or copayment provisions that are greater than those for physical illness generally.

(7) As used in this section, “diabetes” includes all of the following:

(a) Gestational diabetes.

(b) Insulin-dependent diabetes.

(c) Non-insulin-dependent diabetes.

History: Add. 2000, Act 425, Eff. Mar. 28, 2001.

Popular name: Act 218

500.3406q Off-label use of approved drug; coverage; conditions; compliance; use of copayment, deductible, sanction, or utilization control; limitation; definitions.

Sec. 3406q. (1) An expense-incurred hospital, medical, or surgical policy or certificate delivered, issued for delivery, or renewed in this state that provides pharmaceutical coverage and a health maintenance organization contract that provides pharmaceutical coverage shall provide coverage for an off-label use of a federal food and drug administration approved drug and the reasonable cost of supplies medically necessary to administer the drug.

(2) Coverage for a drug under subsection (1) applies if all of the following conditions are met:

(a) The drug is approved by the federal food and drug administration.

(b) The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:

(*i*) A life-threatening condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(*ii*) A chronic and seriously debilitating condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(c) The drug has been recognized for treatment for the condition for which it is prescribed by 1 of the following:

(*i*) The American medical association drug evaluations.

(*ii*) The American hospital formulary service drug information.

(*iii*) The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional".

(*iv*) Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

(3) Upon request, the prescribing allopathic or osteopathic physician shall supply to the insurer or health maintenance organization documentation supporting compliance with subsection (2).

(4) This section does not prohibit the use of a copayment, deductible, sanction, or a mechanism for appropriately controlling the utilization of a drug that is prescribed for a use different from the use for which the drug has been approved by the food and drug administration. This may include prior approval or a drug utilization review program. Any copayment, deductible, sanction, prior approval, drug utilization review program, or mechanism described in this subsection shall not be more restrictive than for prescription coverage generally.

(5) As used in this section:

(a) "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

(b) "Life-threatening" means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.

(c) "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the federal food and drug administration.

History: Add. 2002, Act 538, Eff. Jan. 22, 2003;—Am. 2003, Act 88, Eff. Jan. 23, 2004.

Popular name: Act 218

500.3406r Coverage for obstetrical and gynecological services by physician or nurse midwife.

Sec. 3406r. (1) As used in this section, "nurse midwife" means an individual licensed as a registered professional nurse under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, who has been issued a specialty certification in the practice of nurse midwifery by the Michigan board of nursing under section 17210 of the public health code, 1978 PA 368, MCL 333.17210.

(2) Effective March 1, 2005, a health maintenance organization contract and an expense-incurred hospital, medical, or surgical policy or certificate that provides coverage for obstetrical and gynecological services shall include coverage for obstetrical and gynecological services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification or shall do 1 or both of the following:

(a) Offer to provide coverage for obstetrical and gynecological services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification.

(b) Offer to provide coverage for maternity services and gynecological services rendered during pre- and post-natal care whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification.

History: Add. 2004, Act 375, Imd. Eff. Oct. 11, 2004.

500.3407 Entire contract; changes.

Sec. 3407. There shall be a provision as follows:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3407a Conduct on behalf of or information provided to insured by health care provider; prohibition or discouragement by disability insurer.

Sec. 3407a. A disability insurer shall not prohibit or discourage a health care provider from advocating on behalf of an insured for appropriate medical treatment options pursuant to the grievance procedure in section 2213 or from discussing with an insured or provider any of the following:

(a) Health care treatments and services.

(b) Quality assurance plans required by law, if applicable.

(c) The financial relationships between the insurer and the health care provider including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

History: Add. 1997, Act 66, Imd. Eff. July 15, 1997.

Popular name: Act 218

500.3407b Undergoing genetic testing as condition of issuing, renewing, or continuing policy or certificate; disclosure of genetic testing or genetic information; prohibitions; "genetic information" and "genetic test" defined.

Sec. 3407b. (1) An expense-incurred hospital, medical, or surgical policy or certificate delivered, issued for delivery, or renewed in this state shall not require an insured or his or her dependent or an asymptomatic applicant for insurance or his or her asymptomatic dependent to do either of the following:

(a) Undergo genetic testing before issuing, renewing, or continuing the policy or certificate in this state.

(b) Disclose whether genetic testing has been conducted or the results of genetic testing or genetic information.

(2) This section does not prohibit an insurer from requiring an applicant for an expense-incurred hospital, medical, or surgical policy or certificate to answer questions concerning family history.

(3) As used in this section:

(a) "Clinical purposes" includes all of the following:

(*i*) Predicted risk of diseases.

(*ii*) Identifying carriers for single-gene disorders.

(*iii*) Establishing prenatal and clinical diagnosis or prognosis.

(*iv*) Prenatal, newborn, and other carrier screening, as well as testing in high-risk families.

(*v*) Tests for metabolites if undertaken with high probability that an excess or deficiency of the metabolite indicates or suggests the presence of heritable mutations in single genes.

(*vi*) Other tests if their intended purpose is diagnosis of a presymptomatic genetic condition.

(b) "Genetic information" means information about a gene, gene product, or inherited characteristic derived from a genetic test.

(c) "Genetic test" means the analysis of human DNA, RNA, chromosomes, and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence, or mutation of a gene or chromosome in order to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including, but not limited to, a chemical analysis, of body fluids, unless conducted specifically to determine the presence, absence, or mutation of a gene or chromosome.

History: Add. 2000, Act 27, Imd. Eff. Mar. 15, 2000.

Popular name: Act 218

500.3408 Time limit on certain defenses; incontestability.

Sec. 3408. There shall be a provision as follows:

TIME LIMIT ON CERTAIN DEFENSES: (a) After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 3-year period.

(The foregoing policy provisions shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial 3-year period, nor to limit the application of sections 3432 (change of occupation), 3434 (misstatement of age), 3436 (other insurance—same insurer), 3438 (insurance with other insurers—provision of service or expense incurred basis), and 3440 (insurance with other insurers) in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least 5 years from its

date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption **"INCONTESTABLE":**)

After this policy has been in force for a period of 3 years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after 3 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(For the purpose of permitting insurers to use a uniform policy in several states, the insurer is permitted to print in the policy form in required provisions (a) and (b) above the term of "3 years". Nevertheless, the provisions of the contract and text of the statute to the contrary notwithstanding, the time limits for said defenses under any contract delivered or issued for delivery to any person in this state shall not exceed 2 years.)

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3409 Disability insurance; mandatory notices as to cancellation and refund of premium.

Sec. 3409. (1) Except as provided in subsection (2), a disability insurance, other than group and blanket insurance, delivered or issued for delivery to a person in this state shall contain the following notice, in substance printed or stamped on the front page and made a permanent part of the policy:

Cancellation during first 10 days: During a period of 10 days after the date the policyholder receives the policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to such notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

Cancellation after 10 days: A policyholder may cancel the policy after the first 10 days following receipt of the policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer shall promptly refund to the policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

(2) A policy of disability insurance which is sold through solicitation to a person who is eligible for medicare shall contain the following notice, in substance printed or stamped on the front page and made a permanent part of the policy:

Cancellation during the first 30 days: During a period of 30 days after the date the policyholder receives the policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to such notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

Cancellation after 30 days: A policyholder may cancel the policy after the first 30 days following receipt of the policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer shall promptly refund to the policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

History: Add. 1978, Act 144, Eff. Aug. 10, 1978;—Am. 1980, Act 329, Imd. Eff. Dec. 19, 1980;—Am. 1990, Act 170, Imd. Eff. July 2, 1990.

Popular name: Act 218

500.3410 Grace period; provision required.

Sec. 3410. There shall be a provision as follows:

GRACE PERIOD: A grace period of ..... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof." A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "unless not less than 5 days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted,").

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3411 Reinstatement; provision required.

Sec. 3411. There shall be a provision as follows:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: Provided, however, That if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least 5 years from its date of issue.)

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3412 Notice of claim; provision required.

Sec. 3412. There shall be a provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss-of-time benefit which may be payable for at least 2 years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least 2 years, he shall, at least once in every 6 months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of 6 months preceding the date on which such notice is actually given.)

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3413 Claim forms; provision required.

Sec. 3413. There shall be a provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3414 Proofs of loss; provision required.

Sec. 3414. There shall be a provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3416 Time of payment of claims; provision required.

Sec. 3416. There shall be a provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3418 Payment of claims provision required.

Sec. 3418. There shall be a provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed $1,000.00), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services.)

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1984, Act 280, Imd. Eff. Dec. 20, 1984.

Popular name: Act 218

500.3420 Physical examinations and autopsy; provision required.

Sec. 3420. There shall be a provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3422 Legal actions; provision required.

Sec. 3422. There shall be a provision as follows:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3424 Change of beneficiary; provision required.

Sec. 3424. There shall be a provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3425 Health insurance policies; coverage for intermediate and outpatient care for substance abuse required; option to decline; charges, terms and conditions; reduction of coverage; deductibles and copayment provisions; minimum coverage; adjustment; definitions; effective date of section.

Sec. 3425. (1) Each insurer offering health insurance policies in this state shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all contracts for, group and individual hospital, medical, surgical expense-incurred health insurance policies other than limited classification policies.

(2) In the case of group health insurance policies, if the premium for a group health insurance policy would be increased by 3% or more because of the provision of the coverage required under subsection (1), the master policyholder shall have the option to decline the coverage required to be provided under subsection (1). In the case of individual health insurance policies, if the total premium for all individual health insurance policies of an insurer would be increased by 3% or more because of the provision of the coverage required under subsection (1) in all of those policies, the named insured of each such policy shall have the option to decline the coverage required to be provided under subsection (1).

(3) Charges, terms, and conditions for the coverage required to be provided under subsection (1) shall not be less favorable than the maximum prescribed for any other comparable service.

(4) The coverage required to be provided under subsection (1) shall not be reduced by terms or conditions which apply to other items of coverage in a health insurance policy, group or individual. This subsection shall not be construed to prohibit health insurance policies that provide for deductibles and copayment provisions for coverage for intermediate and outpatient care for substance abuse.

(5) The coverage required to be provided under subsection (1) shall, at a minimum, provide for up to $1,500.00 in benefits for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(6) As used in this section:

(a) “Health insurance policy” means a hospital, medical, or surgical expense-incurred policy.

(b) “Intermediate care” means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(c) “Limited classification policy” means an accident only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

(d) “Outpatient care” means the use, on both a scheduled and a nonscheduled basis, of any or all of the

following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(e) "Substance abuse" means that term as defined in section 6107 of Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

(7) This section shall take effect January 1, 1982.

History: Add. 1980, Act 429, Eff. Jan. 1, 1982.

Popular name: Act 218

500.3426 Offer of wellness coverage by insurer.

Sec. 3426. (1) Each insurer providing a group expense-incurred hospital, medical, or surgical certificate delivered, issued for delivery, or renewed in this state and each health maintenance organization may offer group wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program offered by the employer. The employer shall provide evidence of demonstrative maintenance or improvement of the insureds' or enrollees' health behaviors as determined by assessments of agreed-upon health status indicators between the employer and the health insurer or health maintenance organization. Any rebate of premium provided by the health insurer or health maintenance organization is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 10% of paid premiums. Each insurer and each health maintenance organization shall make available to employers all wellness coverage plans that the insurer or health maintenance organization markets to employers in this state.

(2) Each insurer providing an individual or family expense-incurred hospital, medical, or surgical policy delivered, issued for delivery, or renewed in this state and each health maintenance organization may offer individual and family wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program approved by the insurer or health maintenance organization. The insured or enrollee shall provide evidence of demonstrative maintenance or improvement of the individual's or family's health behaviors as determined by assessments of agreed-upon health status indicators between the insured or enrollee and the health insurer or health maintenance organization. Any rebate of premium provided by the health insurer or health maintenance organization is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 10% of paid premiums. Each insurer and each health maintenance organization shall make available to individuals and families all wellness coverage plans that the insurer or health maintenance organization markets to individuals and families in this state.

(3) An insurer and a health maintenance organization are not required to continue any health behavior wellness, maintenance, or improvement program or to continue any incentive associated with a health behavior wellness, maintenance, or improvement program.

History: Add. 2006, Act 412, Eff. Mar. 30, 2007.

Compiler's note: Enacting section 2 of Act 412 of 2006 provides:

"Enacting section 2. It is only the intent of this amendatory act to promote the availability of health behavior wellness, maintenance, and improvement programs."

Popular name: Act 218

500.3430 Optional policy provisions; insurance commissioner's approval.

Sec. 3430. Except as provided in subsection (2) of section 3406 (inapplicable or inconsistent provisions), no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth in sections 3432 through 3454 unless such provisions are in the words in which the same appear in such sections: Provided, however, That the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in the pertinent section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3432 Change of occupation; optional provision.

Sec. 3432. There may be a provision as follows:

CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to any occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3434 Misstatement of age; optional provision.

Sec. 3434. There may be a provision as follows:

MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3436 Other insurance with same insurer; optional provision.

Sec. 3436. There may be a provision as follows:

OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... (insert type of coverage or coverages) in excess of $..... (insert maximum limit of indemnity or indemnities), the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

Or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3438 Insurance with other insurers; optional provision.

Sec. 3438. There may be a provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

(If the foregoing policy provision is included in a policy which also contains the policy provision set out in section 3440 there shall be added to the caption of the foregoing provision the phrase **"—EXPENSE INCURRED BENEFITS".** The insurer may, at its option, include in this provision a definition of "other

valid coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".)

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3439 Insurance with other insurers; allowable provisions; report to legislature.

Sec. 3439. (1) There may be a provision as follows:

Insurance with other insurers: Benefits payable by this policy may be limited if there is other valid coverage not with this insurer that provides benefits for the same loss on an expense-incurred basis. If this insurer is not given written notice on the application for this coverage that other valid coverage exists, or if other coverage is acquired after the effective date of this coverage, the only liability under any expense-incurred coverage of this policy shall be the amount of the covered claim that exceeds the benefits payable by the other coverage. Benefits paid or payable by a primary insurer shall be applied to satisfy any deductibles, coinsurance, and copayments with this policy. Payments made by a primary insurer shall not be applied to reduce the policy maximum limits on this policy. "Other coverage" includes any plan that provides coverage under an expense-incurred hospital, medical, surgical, or sick care insurance policy or certificate, hospital or medical service subscriber contract, medical practice or other prepayment plan, or other expense-incurred plan or program. "Other coverage" does not include medicaid, hospital daily indemnity plans, specified disease only policies, or limited occurrence policies that provide only for intensive care or coronary care at a hospital, first aid outpatient medical expenses resulting from accidents, or specified accidents such as travel accidents. If there is more than 1 policy covering the same loss and the other policy has a provision similar to this provision and liability of this insurer is not determined pursuant to the foregoing provisions, each insurer shall pay an equal share of the covered expenses for the claim. This policy is secondary to workers' compensation coverages, automobile personal protection benefit plans that do not have a coordination of benefits provision, and medicare as permitted by federal law.

(2) The commissioner shall report to the legislature 1 year and 2 years after the effective date of this section on what, if any, cost savings have accrued to policyholders and insurers by the implementation of this section.

History: Add. 1990, Act 350, Imd. Eff. Dec. 26, 1990.

Popular name: Act 218

500.3440 Insurance with other insurers; other benefits; optional provision.

Sec. 3440. There may be a provision as follows:

INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice, including the indemnities under this policy, bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined. If the foregoing policy provision is included in a policy which also contains the policy provision set out in section 3438 there shall be added to the caption of the foregoing provision the phrase **"—OTHER BENEFITS".** The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy

provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any worker's compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice, unless the policy contains provisions for the reduction of benefits otherwise payable under the policy by the amount of income from other sources that the insured or the insured's dependents are qualified to receive due to the insured's age or disability from worker's compensation or federal social security, if at the time the policy was issued, the premium had been appropriately reduced to reflect such anticipated reduction in benefits. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 52, Imd. Eff. June 22, 1987.

Compiler's note: Section 2 of Act 52 of 1987 provides:

"The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act apply to all insurance policies issued on or after January 1, 1957 that were either approved by the commissioner on or after January 1, 1957 or subject to an order of the commissioner exempting policies from filing on or after September 1, 1968. The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act are intended to codify and approve long-standing administrative and commercial practice taken and approved by the commissioner pursuant to his or her legal authority. This amendatory act shall serve to cure and clarify any misinterpretation of the operation of such sections since the effective date of their original enactment. It is the intent of this amendatory act to rectify the misconstruction of the insurance code of 1956 by the court of appeals in Bill v Northwestern National Life Insurance Company 143 Mich App 766 with respect to the power of the insurance commissioner to exempt certain insurance documents from filing requirements and the offsetting of social security benefits against disability income insurance benefits. This amendatory act does not affect the relationship between disability insurance benefits and personal protection insurance benefits as provided in Federal Kemper v Health Insurance Administration Inc. 424 Mich 537."

Popular name: Act 218

500.3444 Relation of earnings to insurance; optional provision.

Sec. 3444. There may be a provision as follows:

RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200.00 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time. (The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or (2) in the case of a policy issued after age 44, for at least 5 years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3446 Unpaid premium; optional provision.

Sec. 3446. There may be a provision as follows:

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3448 Cancellation; optional provision.

Sec. 3448. There may be a provision as follows:

CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the insured, stating when, not less than 5 days thereafter, the cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer may retain the pro rata premium for the expired time or $25.00, whichever is greater. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 168, Imd. Eff. Nov. 9, 1987;—Am. 1990, Act 170, Imd. Eff. July 2, 1990.

Popular name: Act 218

500.3450 Conformity with state statutes; optional provision.

Sec. 3450. There may be a provision as follows:

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3452 Illegal occupation; optional provision.

Sec. 3452. There may be a provision as follows:

ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3454 Repealed. 1980, Act 429, Eff. Mar. 31, 1981.

Compiler's note: The repealed section pertained to intoxicants and narcotics.

Popular name: Act 218

500.3460 Order of certain policy provisions.

Sec. 3460. The provisions which are the subject of sections 3406 through 3454, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3462 Third party ownership of policy.

Sec. 3462. The word “insured”, as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3464 Foreign or alien insurers; provision required by other state law; domestic insurers; provision required by other state or country.

Sec. 3464. (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3466 Filing procedure; insurance commissioner, regulatory powers.

Sec. 3466. The commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this chapter as are necessary, proper or advisable to the administration of this chapter. This provision shall not abridge any other authority granted the commissioner by law.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3468 Provisions violating code; construction of noncomplying policies and provisions.

Sec. 3468. (1) No policy provision which is not subject to sections 3406 through 3454 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

(2) A policy delivered or issued for delivery to any person in this state in violation of this insurance code shall be held valid but shall be construed as provided in this code. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3470 Age of insured; provision regulations.

Sec. 3470. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3474 Risk classification; rates; filing requirements.

Sec. 3474. No policy of insurance against loss or expense from the sickness, or from the bodily injury or death from accident of the insured, nor any application, rider or endorsement to be used in connection therewith, shall be delivered or issued for delivery to any person in this state, until the classification of risks and any premium rates pertaining thereto have been filed with the department of insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3475 Reimbursement for services by licensed psychologist, podiatrist, or chiropractor; section inapplicable to policy or certificate involving prudent purchaser agreement.

Sec. 3475. Notwithstanding any provision of any policy of insurance or certificate, if an insurance policy or certificate provides for reimbursement for any service which may be legally performed by a person fully licensed as a psychologist under part 182 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.18201 to 333.18237 of the Michigan Compiled Laws; by a podiatrist licensed under part 180 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.18001 to 333.18033 of the Michigan Compiled Laws; by a chiropractor licensed under part 164 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16401 to 333.16431 of the Michigan Compiled Laws; reimbursement under the insurance policy or certificate shall not be denied if the service is rendered by a person fully licensed as a psychologist under part 182 of the public health code, Act No. 368 of the Public Acts of 1978; by a podiatrist licensed under part 180 of the public health code, Act No. 368 of the Public Acts of 1978; or by a chiropractor licensed under part 164 of the public health code, Act No. 368 of the Public Acts of 1978; within the statutory provisions provided in his or her individual practice act. This section shall not be construed as requiring the coverage for a psychologist in any insurance policy. This section shall not apply to a policy or certificate written pursuant to section 3405, 3631, or 3709 involving a prudent purchaser

agreement.

History: Add. 1963, Act 56, Eff. Sept. 6, 1963;—Am. 1966, Act 92, Imd. Eff. June 15, 1966;—Am. 1968, Act 182, Eff. Nov. 15, 1968;—Am. 1984, Act 280, Imd. Eff. Dec. 20, 1984.

Popular name: Act 218

500.3480 Repealed. 1963, Act 127, Eff. Sept. 6, 1963.

Compiler's note: The section imposed penalties for violation of disability insurance provisions.

Popular name: Act 218